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Family Therapists' Adult Attachment Styles and the Therapeutic Alliance

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Manuscripts

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Family Therapists’ Adult Attachment Styles and the Therapeutic Alliance

Abstract

A therapist’s adult attachment style may affect their ability to form effective therapeutic alliances. An analysis of semi-structured interviews with 11 family therapists explored the relationship between their adult attachment styles as assessed using a self-report measure and their perceptions of the therapeutic alliance. A framework analysis was employed, using four dimensions of therapeutic alliance: engagement in the therapeutic process, emotional connection to the therapist, safety within the therapeutic system and shared sense of purpose within the family. Responses were compared according to ‘secure’ and ‘insecure’ attachment styles. There were no substantial differences in therapists’ accounts of their approach to engagement and creating a sense of safety, however they differed in their approaches to managing clients’ hostility. ‘Secure’ and ‘insecure’ therapists differed in their emotional connections to family members. Training and supervision could incorporate understanding of attachment style. Suggestions are made for future research based on this exploratory study.

Running Head: Therapists’ Attachment Styles and Therapeutic Alliance

Family Therapists' Adult Attachment Styles and the Therapeutic Alliance

Key words

Therapists' Attachment Styles, Therapeutic Alliance, Family Therapy

Running Head

Therapists' Attachment Styles and Therapeutic Alliance

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Abstract

Practitioner Points

- Family therapists’ ability to co-create a ‘secure base’ for therapy may be related to their own (adult) attachment security in the face of threat.
- Specifically, therapists with ‘insecure’ attachment styles appear to have difficulty in managing clients’ hostility and close emotional connections to family members.
- Trainee therapists may benefit from understanding their own adult attachment styles and resolving outstanding family-of-origin issues which affect may the therapeutic alliance.
- Work on the self-of-the-therapist as part of continuing personal and professional development could explore adult attachment in group supervision.
- For qualified therapists, clinical supervision of ‘stuck’ cases could usefully include reflection on the interaction between the therapist’s and family attachment styles.

Introduction

The importance of the therapeutic alliance in predicting engagement and outcomes in couple and family therapy is increasingly well established. Friedlander et al.'s (2011) meta-analysis of 24 studies showed that the overall effect size was almost identical to that reported for the many more numerous studies of therapeutic alliance in individual psychotherapy.

Nevertheless, in discussing these findings, the reviewers commented that in comparison to individual therapy little was known about the extent to which the individual characteristics of family therapists might affect their ability to form effective therapeutic alliances.

Specifically they noted, "Given its importance for intimacy and cohesion, [therapist's] attachment may well moderate the alliance-outcome relationship..." (p. 31).

Friedlander and colleagues' suggestion is consistent with Byng-Hall's (1995) view of the role that the family therapist plays in stressful situations where s/he can become a temporary attachment figure to clients. The aim is to use therapy as a secure base to "...assist the family to explore ways of improving security of the family's attachment network" (p. 51).

Therapists' different abilities to co-create a secure base are likely to depend on their own attachment security. Before examining this proposition further, we shall describe two key studies of adult attachment style and alliance in individual psychotherapy. But first, it may be useful to define attachment styles as

"...patterns of expectations, needs, emotions and social behaviour that result from a particular history of attachment experiences, usually beginning in relationships with parents" (Fraley and Shaver in Mikulincer and Shaver, 2007).

As we have outlined elsewhere (Authors, published), interactions with caregivers help children to develop internal working models, that is, beliefs about the attachment figure and

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3 themselves that guide behaviours and expectations in the parent-child relationship (Dolan et
4 al., 1993). As Vetere and Dallos (2008) explain, these models are thought to ‘...guide our
5 actions, thoughts and feelings and help us to make predictions about behaviour in relationships.
6 They are intimately concerned with protection and safety in relationships...(p.375).

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12 Observational studies (Ainsworth et al., 1978, Main et al., 1985) described ‘secure’ and
13 ‘insecure’ attachment styles, the latter including ‘avoidant’, ‘anxious’, ‘disorganized’,
14 ‘dismissing’ and ‘preoccupied’. Incidentally, while these terms may appear pejorative when used
15 in reference to individuals, as in this paper, but it should be remembered that they describe styles
16 of relating not people. For this reason, we include them in inverted commas.

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22 Vetere and Dallos (2008) emphasised that ‘...these response patterns emerge at times of
23 attachment threat, and attachment insecurity.” (p.375). Conversely, we should not assume that an
24 individual’s behaviour and responses in non-threatening situations are necessarily governed by their
25 adult attachment style. Numerous other factors may be relevant, including, in the context of
26 family therapy, family and therapist’s culture, social class, gender and temperament and for the
27 therapist, the influence of training and supervision. Nevertheless, the proposition to be explored
28 in this paper is that a therapist’s attachment style may come to the fore when therapy becomes
29 difficult and she is personally challenged, and that this may affect the therapeutic alliance. Some
30 evidence supporting this idea is presented below. But first, we consider the extent to which
31 attachment styles are amenable to change.

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45 Bowlby (1973) believed that attachment styles were relatively stable throughout the life span,
46 although a longitudinal study by Waters et al. (2000) suggested that they could be disrupted.
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Therapists, of course, believe in the possibility of change. Vetere and Dallos (2008, p. 376)
pointed out that changes associated with the family life cycle may offer natural opportunities for
change in ways of relating. They give the hypothetical example of a mother with an avoidant
attachment style who, with the support of a securely attached partner, responds to the demands of

a new baby for love and care and becomes emotionally connected and secure. Models of therapy grounded in attachment theory and systemic practice (Crittenden, 1997, Dallos and Vetere, 2012, Vetere and Dallos, 2008, Diamond and Stern, 2003, Hughes, 2007) present convincing approaches to assessment and change and Diamond and colleagues (2010) have presented preliminary evidence of effectiveness in a small randomised controlled trial of 'Attachment-Based Family Therapy'. Meanwhile, developmental psychologists and psychiatrists Sroufe and Siegel (2011) have argued that attachment theory provides an understanding of adult psychopathology based on developmental pathways which may nevertheless be 'corrected': "Early experience influences later development, but it isn't fate" (p.39). However, they emphasise that change can be very difficult because people can get "lost in familiar places", recreating patterns of early behaviour throughout their lives. A role for the therapist is to "...bring awareness to such patterns and intentionally create new pathways for clients to take..." (p.52). As we shall suggest later, this may also be a role for the trainer and supervisor.

Therapist attachment style and therapeutic alliance

A pioneering investigation in the US by Dozier et al. (1994) assessed, using the Adult Attachment Interview (AAI, George et al., 1985), the adult attachment styles of case managers working with individual clients with serious mental health problems. They subsequently interviewed the case managers by telephone over the next five months enquiring about their contacts with their clients and then coded the interventions described. The researchers concluded that case managers with a 'secure' adult attachment style attended successfully to the underlying needs of clients; in contrast, 'insecure' therapists reacted according to their clients' presentations or attachment strategies and failed to challenge their clients' destructive models of relationships.

Mohr et al. (2005) assessed the adult attachment styles of both clients (US university

students) and the trainee counselors with whom they were working using a self-report measure, the Experiences in Close Relationships Scale (Brennan et al., 1998). Recordings of initial therapy sessions were rated for 'smoothness' and 'counter-transference'. The latter was more frequent when there was a difference between the client's and counselor's attachment style. Thus, counselors with 'dismissing' attachment styles were hostile, critical and rejecting when faced with clients with 'preoccupied' attachment styles; conversely, counselors with 'preoccupied' attachment styles reacted similarly towards 'dismissing' clients. The highest levels of distancing and hostile counter-transference occurred in the relationship between 'preoccupied' clients and 'avoidant' counselors. The authors concluded that these dynamics were evident when the client's relational style challenged the counselor's own emotion regulation strategies.

Wittenborn (2012), also in the US, has published the only previous investigation of this topic in the field of couple and family therapy. She followed Dozier et al. in assessing seven novice therapists' attachment styles using the AAI and Mohr and colleagues in analyzing recordings of interviews, in this case, of simulated therapy with four 'healthy' volunteer couples. Three of the therapists were rated 'secure', two as 'secure with elements of preoccupation' and one as 'dismissing'. The remaining therapist could not be classified and data were excluded from the analysis.

Wittenborn employed a combination of measures to assess the therapists' self-perceived emotional regulation, the couples' perceptions of the therapeutic alliance (the Working Alliance Inventory; Horvath and Greenberg, 1989) and their ratings of the 'smoothness' and 'positivity' of the session as well as a feedback questionnaire. Video-recordings were rated using an Emotional Focused Therapy fidelity scale (Denton et al., 2009). Indicative findings were that 'secure' therapists were more competent at working with clients' attachment needs

and emotions than the 'insecure' therapists, mirroring conclusions from Dozier and colleagues' study reported above. However, the obvious limitation of Wittenborn's study was its reliance on quantitative measures with a very small sample of novice therapists which precluded inferential statistical analysis.

Aim

This paper reports an exploratory investigation of the relationship between family therapists' adult attachment styles and their perceptions of the therapeutic alliance in family therapy. It forms one part of an investigation of the relationship between adult attachment style and family therapists' approach to therapy; the impact of therapists' family of origin experiences on career choice and the integration of personal experiences and therapeutic practice is reported elsewhere (Authors, published).

Methods

In contrast to the quasi-quantitative approach adopted by Wittenborn (2012) we considered that an in-depth qualitative study with a sample purposively selected to represent the range of possible therapist adult attachment style was more appropriate for an exploratory study.

The sample of participants was drawn from respondents to an online survey (2009) of family therapists' attachment styles which is reported elsewhere (Authors' own). Respondents were all registered as family/systemic therapists with the United Kingdom of Council of Psychotherapy. Adult attachment style was assessed using the 36-item Experiences in Close Relationships (ECR) Questionnaire. Responses can be used to categorize respondents' attachment styles as 'secure', 'preoccupied', 'dismissing' or 'fearful' (Brennan et al., 1998). The measure has internal reliability scores around .90 and test-retest coefficients ranging between .50 and .75 (Mikulincer and Shaver, 2007).

At the conclusion of the survey, respondents were invited to participate in a follow up interview to explore their past experiences, interactions between their personal self and their professional self, and the meanings that those experiences had for them. As advised by the Research Ethics Committee, they were not informed of their assessed attachment style until after the interview in case this information compromised their responses.

Interview Guide

The semi-structured interview included a central focus on the four dimensions of the therapeutic alliance identified by Friedlander et al.’s (2006a) ‘trans-theoretical’ model: engagement in the therapeutic process, emotional connection to the therapist, safety within the therapeutic system and shared sense of purpose within the family. Participants were also asked to bring for discussion a case that reflected positive and negative examples of alliance building. The second section of the interview (reported elsewhere) adopted a free-flowing approach to explore their past experiences, interactions between their personal self and their professional self.

Data Analysis

All interviews were transcribed word-for-word and data were uploaded onto the MAXQDA software for text analysis. Given the specific focus of this part of the interview, a ‘framework’ or ‘template’ approach to analysis (Ritchie and Spencer, 1994) was adopted. Thus, the participants’ responses were initially coded by the first author, according to the four alliance dimensions identified by Friedlander et al.’s (2006a) model (master themes). Sub themes were identified with reference to the manual for SOFTA (System for Observing Family Therapy Alliance; Friedlander et al. (2006b). This manual is designed for use by trained raters of video-recordings of therapy sessions and focuses specifically on observations

of therapist behaviours. The coding was reviewed by the second author. In practice, the SOFTA categories proved a little too specific and behaviourally focused and did not take into account the participants' expressions of their feelings; consequently the categories were merged into higher level themes.

Participants

The present paper is based on the responses of eleven respondents to the online survey who volunteered to participate in a follow-up interview. Following a protocol agreed with the NHS Research Ethics Committee, they received further information about the study and were asked if they consented to recordings of the interviews and to the publication of findings, including direct quotations following anonymisation. Following standard consent procedures, they were interviewed at a place of their own choosing. According to the self-report ECR measure of adult attachment, three each were assessed as 'secure', 'preoccupied' and 'fearful' attachment styles; and two were 'dismissing'. Demographic data are shown in Table 1. The names are, of course, pseudonyms.

TABLE 1 ABOUT HERE

Findings

All four dimensions of therapeutic alliance were apparent in the therapists' accounts of their practice. Table 2 summarises the themes and subthemes, together with an indication of whether there were differences associated with the therapists' attachment styles. There were no substantial differences in therapists' accounts of their approach to engagement within the therapeutic system. Similarly, all therapists sought to create a sense of safety by providing structure and emphasising confidentiality and by explaining that therapy necessarily involves taking risks and discussing private matters. However, there were differences in their

approaches to containing or managing clients’ hostility in the sessions. Therapists all discussed encouraging family members to compromise, but there were differences in the extent to which they encouraged them to ask each other for their perspectives. Finally, therapists differed in the closeness of their emotional connections to family members, including their approaches to the use of self-disclosure. The findings reported below focus on the themes in which differences in responses were apparent in relation to the therapists’ adult attachment styles.

TABLE TWO ABOUT HERE

Emotional Connection within the Therapeutic System

Therapists Express Empathy for the Clients’ Struggle

Empathy is an understanding of the experience of another person. The therapist’s ability to convey the message that he or she understands the experience of the client (Friedlander et al., 2005) is captured in this category. In family therapy, family members’ accounts of their lives and troubles can be affecting. ‘Secure’ therapists like Betty and Carl described acknowledging their own feelings about their clients’ struggles as well as responding.

I would always tend to hold on to my tears but if I sort of felt, actually, this is part of what we were talking about, I might say, “Look when I’m talking to people and really sad that things have happened, my eyes swell up like this. It’s not because I don’t want to hear what you’re saying. What you’re saying is really sad. I’ll acknowledge my sadness but I try and do it after we’ve had the chance to acknowledge theirs.

(Betty ‘secure’)

Carl stated that he would acknowledge the feelings involved. He also commented that it would be a mistake to ignore the feelings that arose in the session.

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3 I try to acknowledge it. Often you can tell if people are angry. I think it's a
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5 mistake to ignore that all and carry-on. I'm not put off by people not liking
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7 me, being angry with me, and [I] try to be interested in understanding their
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9 point of views and then I think people then will be engaged, will feel safe.
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12 (Carl- 'secure')

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14 For therapists with a 'secure' attachment style, three different aspects were apparent when
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16 conveying empathy towards clients: acknowledging the clients' feelings; acknowledging
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18 their own feelings; and conveying an understanding of the clients' point of view and being
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20 able to respond to their vulnerability. In comparison, therapists with 'insecure' attachment
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22 styles acknowledged their clients' feelings, but did not describe acknowledging their own
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24 feelings. For example, in discussing her work with an estranged mother and teenage daughter,
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26 Di ('preoccupied') mentioned acknowledging their difficulty but did not provide any further
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28 explanation about her therapeutic response:
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33 So it was, sort of, acknowledging what we're talking about was very
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35 difficult, was very difficult stuff. Yeah it was difficult.
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38 Ken ('fearful') seemed very cautious about responding to a client's evident distress. He
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40 described waiting for the right moment in order to acknowledge his clients' feelings. Having
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42 done so, he would then seek their permission to continue with the session:
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46 So, I guess, kind of, you know, waiting, waiting for a moment when it feels
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48 appropriate to offer something like a tissue but also acknowledging that they
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50 might be upset and you know checking with them if it's OK to carry on
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52 because sometimes they can be quite distressed.
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55 Harry ('dismissing') described a similar approach to a family member becoming upset:
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I guess it's, ultimately, to be attentive to that. I notice it by, you know, by having tissues, by offering compassion, things like that, but not to be so organised by that level of distress that it paralyses the process of therapy. So to be organised and attentive to it sufficiently.

Fran ('preoccupied') gave an apparently emotionally detached response, with no acknowledgement of her own feelings and what she would do to help clients:

Interviewer: When clients show vulnerability in a session, they discuss painful feelings, or they cry in the session, do you attend to that?

Fran: Yes...I always give them some tissues. I say 'It's upsetting isn't it? It's very distressing'. Yeah.

Interviewer: Usually when you do that, what kind of reaction do you get from the clients?

Fran: Usually, they just use the tissues.

Thus, with regard to 'expressing empathy for the clients' struggle, the therapists with 'secure' attachment styles acknowledged their clients' feelings, and acknowledged their own reactions or struggles, while managing to empathise with their clients' difficulties. The 'insecure' therapists, on the other hand, acknowledge their clients' feelings but did not display their own.

Self-Disclosure

Friedlander et al. (2006a) considered that families are attracted to therapists who speak from their personal experience, thus enhancing the emotional connection. However, most therapists in this study, regardless of their attachment style, found this an uncomfortable

topic and had reservations about the use of self-disclosure with families. Thus Andy ('secure') described his awkwardness when asked during his early days of becoming a therapist if he had children:

I used to feel quite awkward when I didn't have children, I was doing this job. Families would say 'Have you got kids?' And I'd say 'No...actually no'..." So there was that fraud feeling - How can you be sitting there and telling me about children when you don't have any?

I used to address it by saying, 'But I've worked with lots of children in similar situations'. But now I've got children. I think I would be able to share with clients that my children aren't perfect...

Carl ('secure'), was concerned about the 'meaning' that self-disclosure might have for his clients. He considered that self-disclosure might have a negative effect if clients perceived the therapist as someone that they could not relate to.

It seems to create more distance rather than a sense of connection. It's as if the therapist does not really get it, they think, "Ooh!...that therapist thinks he can understand us, he doesn't really." So, I found that if you self-disclose, it can seem to close things down a little bit. That's the danger of it. It can work fine, but I feel, often, it has these other consequences.

For the 'preoccupied' therapists (Eleanor, Di and Fran), self-disclosure should not take away from the main focus on the family's concerns. Fran indicated that she would self-disclose about 'her professional experience' but if she had known a family long enough and they were making progress in therapy she might, exceptionally, disclose her personal experiences.

The two therapists with 'dismissing' attachment styles did not really subscribe to the idea of

self-disclosure. Thus, Harry believed that self-disclosure might affect family members' self-disclosure in therapy:

I think there's been certain bits of information that you can disclose about yourself which lessen or, possibly, impact on the disclosure of the people you're in conversation with. You know, they would kind of put a boundary about themselves or something like that.

Similarly, George ('dismissing'), tended, in his own words, to 'shy away' from self-disclosure, arguing that it might exacerbate the notion that the family has to fit into his (the therapist's) norms '...to try to be the type of parents or couple that I think they should be'. Finally, therapists with 'fearful' attachment styles like Joan, were prepared to self-disclose, but in an oblique manner.

I do use self-disclosure but, maybe, I would say, "I know somebody who has this experience" or, "People that I see here generally tell me..." So it wouldn't be direct self-exposure.

Containing or Managing Clients' Hostility

Managing conflicts in the sessions is important for therapeutic work to progress. (Friedlander et al., 2006a) discussed creating a 'safety zone' in order to approach conflict without harm. Many of the therapists described managing clients' hostility as a 'balancing act'. Hostility presents a 'threat' and it is particularly in this situation that therapists' responses are likely to be organised by their internal working models. They attempted to manage it in different ways.

Eleanor ('preoccupied') acknowledged that handling such a situation could be 'tricky'. She described a family where a girl was being verbally abusive to her mother:

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3 So that's really hard, to know how to deal with that. I mean, I let it run for a bit
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5 because, actually, when she's shouting at her mother, it's quite informative as to her
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7 point of view mmm... because, some other time, she's refusing to answer anything
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9 and she sits with you asking stupid questions (tiny laugh). So when she's shouting, at
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11 least it's more real, you know, mmm, but at some point I've actually said, "We can't
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13 carry on like this." So I've asked for something different to happen. [One] time,
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15 because she's an anorexic, I asked for her to be weighed for a little while, just to give
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17 a bit of a break so we can come back again and start fresh.
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21 Eleanor's controlling response, which drew attention specifically to the daughter's condition,
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23 is interesting in terms of its possible effect in splitting the therapeutic alliance: potentially,
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25 'joining' the mother who presumably remained in the therapy room, in coalition against the
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27 daughter.
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30 Carl's response to hostile adolescents in a family session was appreciably more confident and
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32 direct:
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35 Often you can tell if people are angry. I think it's a mistake to ignore that and carry-
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37 on. Often a teenager's scowling and I say "I get the feeling this is not your favourite
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39 place to be today, that's alright, I understand that. Why would you want to come
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41 here?" So, just acknowledging, that I don't mind. I'm not put off by people not liking
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43 me, being angry with me." (Carl, 'secure')
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46 Similarly, Fran ('preoccupied') advocated acknowledging her clients' strong feelings,
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48 anticipating that this would unstick the therapy. She would say:
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51 'I can see you're very angry', or 'You're very upset' or 'It's very
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53 distressing' and I find that, once their emotion has been acknowledged, that
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very often, that's enough to get the therapy moving on again.

George ('dismissing') clearly disagreed that conflict should be allowed to escalate:

You can't allow a couple to have a full blown row in the room. You can, in the sense, but mmm it's not, if it's a row it's one thing but clear verbal abuse and intimidation... and if you're there and you're neutral, you align yourself, you declare yourself, at least disinterested. So, you know I won't necessary stop[the session] but I would stop and say 'Listen you're coming here for me to be part of this because you can do this, I'm pretty sure you can do this at home without my presence' ... Let's talk about what's happening here so we can look at the process'. I'm not ready to allow or to be part of, an abusive sort of...situation.

Betty ('secure') explained that she would try to make family members realise that they are shouting and to reason with them. She used humour to lighten the situation and if that failed, an assertive approach.

If they are actually shouting at each other, I will say things like 'Look, I'm going to have to slow you down there because people in the corridor will get worried, they'll phone security, we really don't need security howling in here'. But, say it was really serious, I would just stand up and say 'Look I'm sorry I can't have this!'

In general, compared to the 'insecure' therapists, the 'secure' therapists' seemed better able to manage and provide a safe setting, acting as the 'secure base' described by Byng-Hall (1995). They illustrated a softer approach, using humour and reasoning as ways to provide safety. 'Insecure' therapists' accounts suggested that they were either quite controlling by putting clients in their place and reminding them of who was in charge, merely

acknowledging the conflict, or instructing clients to do differently, but failing to provide reasons.

Encouraging family members to ask each other for their perspectives

Contributing to a family's shared sense of purpose includes encouraging family members to find out how everyone views the problems, as well as the possible solutions. According to Friedlander et al. (2005), this is a "precursor to the discussion of a compromise" (p. 37).

Joan ('fearful') wanted to hear the 'shift' that family members could make to hearing a different aspect of the problem. Her ability to facilitate the changes seemed important in affirming her self-confidence as a therapist. Reviewing her work with a father-daughter dyad she commented:

...at the end of the day, what my job is to mmm help their relationship, not be critical, or be judgemental and for me to hear the shift mmm. The daughter has been able to be honest with her father and let him know why she's feeling the way that she is. And maybe him feeling he's got a better understanding of why she's angry and why she's doing what she's doing... and that, in some way, I was facilitating that and I helped that to happen.

Betty ('secure') emphasised that family therapy only works if family members dare to express differences. She illustrated how, with one family, the mother of an 'autistic spectrum' boy contradicted the father before predicting that their son would be angry with her for doing so. Betty continued:

And I just said that their mother had done exactly what we would like because, actually, if this is going to be helpful, I need people to say things a little bit different. And then one of the younger ones said 'Well I think

differently too’. And we started having them joke about who can think the most differently. The boy joined in and said ‘Well I’m different to everybody!’. So, just by being a bit playful, emphasizing differences is really useful.

‘Secure’ therapists like Betty seemed to manage the situation well, using skills such as humour and play, while the ‘insecure’ therapists like Joan did not describe how they encouraged clients to ask for each-others’ perspectives or their roles in facilitating the situation.

Discussion

This study was designed to explore the relationship between family therapists’ adult attachment styles and their perceptions of the therapeutic alliance in family therapy. It had a number of limitations. First, the attachment categorization of family therapists relied on their self-report and in a previous paper we showed that self-assessment may be unreliable (Authors’ own). Similarly, the data were drawn from the therapists’ accounts of what they do in therapy; it was not possible to observe their practice and to assess their alliance behaviours. The study did not look at the interaction effects between therapists’ and family members’ attachment styles (as in Dozier et al’s 1994 study). Finally, it was not possible to gain family members’ perspectives of the therapists’ alliance behaviour. (This had been included in the original study design but the therapists were unsuccessful in recruiting participants.)

A strength of the study was that it recruited participants with apparently diverse attachment categories, enabling comparisons to be made. However, the sample size was small, and could not produce data saturation in each category. It is possible that the differences reported here may be due to other factors. In particular, the therapist’s choice of therapy model might

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3 interact with attachment style. For example, therapists adopting the Milan approach
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5 generally adopt a distanced 'neutral' position (Prevatt, 1999, p. 189). They resist sharing
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7 their analysis of the problems and do not offer information about their therapeutic strategies.
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10 (Dallos and Draper, 2000, p. 80). Similarly, the psychoanalytic model focuses less on
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12 engagement and therapists are trained to study unconscious processes (Prevatt, 1999).
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14 Therapists using these approaches may be expected to show less engagement in their work
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16 compared to other models.
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19 All the participants in this study were evidently committed to helping families and brought a lot
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21 of experience to bear in developing the therapeutic relationship in response to families' needs. In
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23 the course of a day's work, they are likely to adopt a range of styles of relating attuned to the
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25 family's own style, a process described by Minuchin (1974) as 'joining'.
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27
28 Nevertheless, according to their own accounts, they were not always equally successful in
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30 establishing the secure base for therapy which Bowlby and Byng-Hall considered essential. The
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32 suggestion here is that in emotionally charged situations of attachment threat, therapists responses
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34 are organised by their internal working models (attachment style). Byng-Hall (2008, p. 139)
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36 discussed this process with reference to 'scripts': "The family's emotional state is likely to arouse
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38 affect in the therapist where the therapist feels she has to take action and risks being drawn into
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40 the family's script." Being able to take a reflective stance enables therapists to understand what
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42 is happening in the family. At the same time, Byng-Hall (2008) stated that therapists need to
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44 "...be aware of their own family scripts and the sort of scenarios that are likely to trigger their
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46 action or to draw them into adopting a particular attitude to what is going on the family" (p. 140).
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49 The associations between therapists' attachment styles and their views on alliance building
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51 were most apparent in their emotional connection within the therapeutic system, compared to
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53 the other alliance dimensions. The therapists in this study with 'secure' attachment styles
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provided a softer approach, utilising humour and reasoning, while their ‘insecure’ counterparts were either too strong in their approach or focused only on safety, despite acknowledging the conflict. Perhaps, it is no surprise that the ‘secure’ therapists were able to provide in-depth feedback, as shown in the present study.

The ‘secure’ therapists explored their personal reactions toward clients or their situations, unlike those with ‘insecure’ attachment styles. This finding is in accordance with the findings of Dozier et al. (1994) who demonstrate the importance of individual therapist’s attachment organisation in dealing with clients. Similarly, Wittenborn (2012) suggested that ‘secure’ therapists were more competent in simulated couple therapy than their ‘insecure’ counterparts. They were skilful at regulating their affect in the event of conflict, also reported by Mohr et al. (2005).

Therapists in this study were divided in relation to the use of self-disclosure. Hanson (2005) showed that clients valued their therapists’ disclosures because they contributed to a real relationship, while the effect of unhelpful disclosures reduced the client’s trust and safety. Helpful self-disclosure increased alliance where it provided a sense of connection, trust, a sense of being deeply understood, an opportunity to identify with the therapist and a sense that the therapist would take responsibility for mistakes (Hanson, 2005). Therefore, self-disclosure, as described by participants should be used cautiously and only if needed, as it might have a negative impact and create more distance if clients perceive therapists as someone that they could not relate to. This view is supported by previous research; most therapists struggled with disclosure as, even with good intentions; disclosure might not necessarily be helpful for clients (Bottrill et al., 2010). Hence, therapists should actively ensure that disclosures are used in a therapeutic manner by taking into account client needs and should, otherwise, protect the client-therapist boundary (Audet and Everall, 2003, Levitt

and Williams, 2010).

Overall, this exploratory study adds to the evidence suggesting that the therapist's attachment style is relevant in building and sustaining the therapeutic alliance. Further, therapists who understand their own attachment styles and how their attachment insecurity might be activated when facing clients of different attachment styles than themselves might be more available to their clients.

Implications for Practice and Training

The survey of family therapists' adult attachment indicated that a high proportion of family therapists manifested 'insecure' styles (Authors' own). In the present paper we have suggested that 'insecure' therapists may experience difficulties in therapeutic encounters with families, particularly when they are more personally challenging. The question which arises is whether it is possible for 'insecure' therapists to modify their ways of relating, or more fundamentally change and develop a secure attachment style, and if so how?

Reflecting on the findings of her own exploratory study, Wittenborn (2012) suggested that clinical supervision might encourage novice therapists' awareness of their own responses and increased ability to act in session based on their new found understanding of themselves. We consider that this is relevant for experienced therapists as well.

As Aponte and Carlsen (2009) pointed out, some pioneers of family therapy, notably Bowen (1972) and Satir (2000) advocated the resolution of issues in the trainee's family of origin as part of training, including the use of genograms. This was discussed by, among others, Haber and Hawley (2004) and Timm and Blow (1999). There are more recent examples of how trainees' self-reflexivity might be developed. Thus, Cheon and Murphy (2007) include an account of one therapist's '...journey to the use of self-of-the-therapist and how self-

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3 awareness, self-knowledge and critical reflexivity worked closely together to inform each
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5 other.’ Totsuka (2014) presented a group exercise to develop supervisees’ self-reflexivity in
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7 relation to ‘issues of difference’. Aponte and Carlsen (2009) offered a ‘structured
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9 instrument’, essentially a written pre-session analysis of each case which includes questions
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11 such as: *Identify your personal challenges working with the client about the focal issue*. The
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13 supervisor provides comment on the responses. The authors explain that these questions are
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15 intended “...to elicit only personal information that relates directly to the case” and that both
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17 parties should “stay within these boundaries”. The authors explained that this procedure is
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19 part of a wider *Person of the Therapist* training model which has “...an assumed goal for
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21 therapists to get [their personal issues] out of their own way in doing therapy.” (p. 398).
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23 Mojta et al. (2014) presented the reflections of seven students who experienced a similarly
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25 structured approach to “self-awareness”, beginning with sensory awareness; most students
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27 reported that their use of this method enhanced the therapeutic relationship with families.
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29 Many of these papers discuss situations in which therapy is apparently ‘blocked’ by the
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31 therapist’s personal issues or blind spots and self-awareness is presumed to be the starting
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33 point. We agree. While some of the challenges described in this paper, e.g. how to respond to
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35 a direct question about having children, could be dealt with in training by rehearsing a
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37 standard response, others are more deep-seated and require a more personal response to the
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39 threat experienced; this, we suggest, is where an understanding of attachment theory comes
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None of the reports of training and supervision mentioned above referenced attachment
theory. However, McCandless and Eatough (2012) published an in-depth empirical study of
reflexive learning, from the perspective of three experienced supervisors. This echoes some

of the themes identified in the present study, notably the parallel between developing a sense of safety within the supervision group and safety within the therapeutic system (one participant explicitly referred to “supervision as a secure base”, p.633). Elsewhere, the authors described a supervisor giving a student “a push” to move on from “...a familiar avoidant pattern, and towards new possibilities” (p.631). The core theme of McCandless and Eatough’s study is the supervisory relationship which also includes a concern with engagement and emotional connection, described here. It is unclear whether or not all three supervisors’ practice was informed by an understanding of adult attachment, but this paper indicates how family therapists’ patterns of insecure attachment may be addressed through supervision.

The above papers are all concerned with the training and supervision of student therapists.

The extent to which clinical supervision of qualified family therapists includes reflection on the person of the therapist and how this affects therapy is unknown. This is presumably something which would have to be negotiated on an individual basis as part of a supervision agreement or terms of reference (e.g. using Aponte and Carlsen’s instrument). Both supervisor and supervisee would have to accept the premise that the therapist’s attachment style was relevant to alliance building and therefore important to discuss, particularly in the context of therapeutic impasse associated with a fractured alliance with family members.

Future Research

This was an exploratory study and the findings should be understood as indicative only. As acknowledged above, the samples within each therapist attachment category were insufficient to produce data saturation. It would be worthwhile repeating the study with larger samples so that conclusions about differences might be more robust.

Future research could utilise SOFTA to complement the data as the study would be able to

measure alliance from different perspectives and look at the differences of alliance building from different time points. The work of Escudero et al. (2008) showed the importance of “...knowledge of which in-session behaviours correspond with clients’ and therapists’ views on the therapeutic process” (p.198). Thus future research could invite participating therapists and family members to respond using the alliance self-report rating scale (SOFTA-s). The design of the study should also involve observation of therapeutic alliance using trained raters (SOFTA-o). The triangulation of data from the therapists and clients’ perspectives and through observation could provide a more valid investigation of the association between attachment styles and therapeutic alliance. Additionally, future research could include interviews with family members in order to include their qualitative perceptions of the therapist’s alliance related behaviours. It would also be interesting to employ a version of Mohr et al.’s (2005) study design in which the attachment styles of (adult) family members are assessed using the ECR so that the interactions between therapist and client be studied. Ultimately, one would want to assess the extent to these interactions influenced the outcomes of therapy.

Research Ethics

The study was approved by the South West 5 NHS Research Ethics Committee (Ref. No 10/H01070/50.).

Acknowledgements

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Table 1 Demographic characteristics of family therapists

Therapist*	Gender	Years of Experience	Main therapeutic model	Attachment style
Andy	Male	> 20 years	Postmodernist/ Collaborative	‘Secure’
Betty	Female	> 20 years	Milan/ Post-Milan	‘Secure’
Carl	Male	>20 years	Integrationist	‘Secure’
Di	Female	11-15 years	Postmodernist/ Collaborative	‘Preoccupied’
Eleanor	Female	0-5 years	Postmodernist/ Collaborative	‘Preoccupied’
Fran	Female	> 20 years	Milan/ Post-Milan	‘Preoccupied’
George	Male	6-10 years	Psychoanalytic/ Psychodynamic	‘Dismissing’
Harry	Male	16-20 years	Milan/ Post-Milan	‘Dismissing’
Izzy	Female	11-15 years	Milan/ Post-Milan	‘Fearful’
Joan	Female	16-20 years	Postmodernist/ Collaborative	‘Fearful’
Ken	Male	6-10 years	Narrative	‘Fearful’

*Pseudonyms

Table 2 Thematic analysis of therapists' responses in relation to dimensions of therapeutic alliance

Master Themes (from SOFTA)	Subthemes	Categories	Comparison according to attachment style
Engagement within the therapeutic system	<ul style="list-style-type: none"> • Therapy as a collaborative decision-making process • Engaging 'difficult', quiet clients or situations 		No significant differences
Emotional connection within the therapeutic system	<ul style="list-style-type: none"> • Therapists express empathy for the clients' struggles • Self-disclosure 		Differences of views, but mixed views on self-disclosure with differences in their reflections
Safety within the therapeutic system	<ul style="list-style-type: none"> • Providing structure and confidentiality • Containing or managing clients' hostility • Therapy involves taking risks or discussing private matters 	<ul style="list-style-type: none"> • Ground rules and how therapy would be structured • Confidentiality and factors that will be shared with third parties 	Differences in "Containing or managing clients' hostility"

Shared sense of purpose within the family	<ul style="list-style-type: none">• Therapists encouraged clients to compromise with each other• Therapist encouraged clients to ask each other for their perspectives• Therapists fail to address one client’s stated concerns by only discussing another client’s concerns		Differences in “Therapists encouraged clients to ask each other for their perspectives”
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For Peer Review